

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

1.) Individual information:

Patient name: _____ SS#: _____ DOB: _____

2.) Information may be disclosed by:

Name of provider or organization releasing information: Lifespan Naturopathic Medicine

Address: 5410 California Avenue SW Suite/Unit #: 102

City: Seattle State: WA Zip: 98136

3.) Information may be disclosed to:

Name of person or organization to receive information: _____

Address: _____ Suite/Unit #: _____

City: _____ State: _____ Zip: _____

Daytime phone number: _____ Fax number: _____

4.) Please disclose the following information: (Check appropriate box. Copy fees may apply.)

- All records from the last _____ years.
- Information from date _____ to date _____.
- Email communication (please specify): _____
- Other (please specify): _____

5.) Information is being disclosed for the following purpose: (Check only one box.)

- Attorney Insurance Doctor Medical Leave Personal Other: _____

Special Authorization:

Information released may include information on the testing, diagnosis, or treatment of HIV/AIDS, sexually transmitted infections, chemical dependency, and/or mental/psychiatric illness. Please initial here to indicate special authorization for the release of this specific information:
_____ (initial)

Rights:

Generally, Lifespan Naturopathic Medicine and any other entity covered by the Health Insurance Portability and Accountability Act of 1996 may not condition treatment, payment, enrollment, or eligibility for benefits on whether an individual signs this authorization. This authorization may be revoked in writing at any time. Once the information that has been authorized to be released has been released, it may no longer be protected under health information privacy laws. If this authorization is revoked, it will not affect any actions already taken by Lifespan Naturopathic Medicine based on this authorization.

Signatures:

Patient/Guardian Signature: _____ Date: _____

Minor Signature (required if minor is aged 13-17 years): _____ Date: _____

This authorization expires 90 days from the date signed **OR** on the date or event indicated here: _____